ZdravReform
ЗдравРеформ

TRIP REPORT NO. UKR-35

ASSISTANCE WITH NATIONAL HEALTH CARE FINANCING LEGISLATION

November 4-15, 1996

Prepared Under Task Order 5761.365
Alexander Telyukov, Ph.D.
Revised by Annemarie Wouters, Ph.D.

Submitted by the Zdrav*Reform* Program to:
AID\ENI\HR\HP

AID Contract No. CCN-0004-C-00-4023-00
Managed by Abt Associates Inc.
with offices in Bethesda, Maryland, U.S.A.
Moscow, Russia; Almaty, Kazakhstan; Kiev, Ukraine

SUMMARY

During this trip, Telyukov worked closely with the MOH including Dr. Korotko, the Deputy Minister for Health Economics and the newly created task force on health care financing legislation. Together, they developed proposals for health care financing legislation which emphasized that such legislation should not focus exclusively on mandatory health insurance funds, but should also encompass a variety of sources and mechanisms for health care financing. It is expected that draft legislation will be submitted by the MOH to the Rada in early 1997. A summary of the recommendations made as a result of this trip is as follows:

1. The MOH should continue to build and strengthen the panel of experts or task force working on health care financing and system reform legislation.

2. The MOH should work to bridge the gap between the health services and health economics units within the Ministry.

3. The MOH should continue develop reform in health care finance, not just as a single-item agenda of mandatory health insurance; rather, it should cover a large range of issues relating to resource generation, resource allocation and service delivery reforms.

4. The MOH should consider setting up a competitive bid process for selecting new computer technology.

5. The MOH (Dr. Bolukh) requested ZRP to assist with the development of the economic and administrative framework for family medicine.

6. The MOH (Dr. Korotko) requested ZRP to assist with conducting a financial feasibility study for the proposed health care insurance law including the calculation of: premium rates for employers, amount of budgetary allocations to the health sector, scope of user charges, cost savings under specific scenarios of restructuring of the health care system.

Telyukov also worked for a short-time with the Railroad Health Insurance Experiment (RRHIE). This was mainly to determine the political situation between the MOH and the RRHIE, and to begin to explore, through some data analysis, how to develop case-base payment systems on an experimental basis. The MOH has decided not to dissolve the railroad health system, but support for the RRHIE is still mixed. A summary of related recommendations is as follows:

1. ZRP and USAID should determine whether the RRHIE experiment should continue as part of the ZRP technical assistance program.

2. If the ZRP project is to develop a package of technical assistance activities for the RRHIE, one component might be to develop a comprehensive plan to test new payment methods, including case-base payment. Some preliminary work has begun in this regard, although a full review would be necessary by ZRP and USAID of what approach should be followed.

BACKGROUND

This is the fourth in a series of short term technical assistance assignment provided by Dr. Telyukov in support of the development of health care finance and system legislation. The initial economic and legal assessment of the Railroad Health Insurance Experiment (RRHIE) occurred in May/June of 1996. In August 1996, Telyukov initiated technical advice to the MOH on health care legislation. At that time, he reviewed several draft legislative proposals. In September 1996, assistance to the MOH of health continued where Telyukov reviewed new drafts of health care legislation and responded to MOH request to draft ideas for Mandatory Health Insurance. This report presents the results of the fourth trip where Telyukov focused primarily on further development of proposals for health care financing legislation, which required working closely with a newly formed task force under the aegis of the MOH. He also provided limited additional technical assistance to the RRHIE as the final task under the RRHIE assessment phase.

ACTIVITIES

Railroad Health Insurance Experiment

Dr. Schedriy and Telyukov discussed technical agenda for the two weeks of Telyukov's stay in Ukraine. They worked out the following tentative plan:

1) Telyukov would contact Dr. Gofman and check on his plans with presenting RRHIE to the Cabinet of Ministers. Based on those plans and timing, Telyukov would guide Dr. Gofman through essential elements of the RRHIE agenda as recommended by ZRP and largely agreed upon with the architects of the experiment.

2) Artur Komkov, TMSU Leading Software Developer would come to Kiev on Friday, November 8th to present to Telyukov the output from his four week effort of rearranging the TMSU data base to adjust its patient registration, utilization control, rate schedule, and billing modules to incentive-based methods of payment as sought to be introduced under RRHIE.

3) Dr. Schedriy would pass some documents to Telyukov to bring him up to date on the future of the National Railroad Administration and its Medical Service. He would forward to Telyukov his own draft proposal of legal and organizational status of the NRA Medical Service, once the document is finished in a few days.

4) Dr. Schedriy would come to Kiev on the week of November 11th to work with Telyukov on the RRHIE blueprint and how it should be presented to the government.

Health Care Financing Legislation

During his assignment with the Ministry of Health, Telyukov focused his work on the health financing and insurance issue. He received from Korotko two most recent draft laws -- one of them is an update from Prof. Prodanchuk's institute, another one from the Supreme Rada, signed by N. Markovs'ka, Member of the Parliament. Telyukov planned to read them and provided his comments on those documents.

Planning Telyukov's work on a broader scale, Dr. Korotko agreed that a panel of experts should be created under the MOH aegis, who could start working with the ZRP team of consultants and grow into a think tank, able to continue on its own with the key policy reform issues. It was agreed that four institutions should be approached in search of such experts: the Health Care Organization Institute, up until recently led by Prof. Prodanchuk; a task force currently working on the economic crisis relief package (Mr. Teryokhin's group), the Institute of the World Economy and International Relations, chaired by Full Academy Member Pakhomov; Prof. Lekhan's laboratory of sociological research in Dnepropetrovsk. Dr. Korotko undertook to contact listed individuals, discuss the idea with them by himself and/or arrange them to meet Telyukov.

On November 5th Telyukov received an urgent request from Dr. Korotko to work for a day and a half with his key staff on the financing section of the Conceptual Outline of Health Care Reform. The Minister expected that section to be submitted by the MOH Economic Administration by close of business on November 6th. Telyukov went down to the assigned work together with Ms. *Lyudmila Podgornaya*, Head, Department of Economic Innovation and Health Insurance, MOH and Ms. *Ella Kovzharova*, Main Expert, Department of Economic Innovation and Health Insurance, MOH. Dr. *Vladimir Evseyev*, Senior Research Staff, the Health Care Organization Institute made part of the team as well, invited by Dr. Korotko according to the previous day decision to broaden the institutional base of reform-related deliberations and activities. On the same day Lyudmila Omelchenko of Zdrav*Reform*/Kiev scheduled a meeting for Telyukov with Dr. *Sergei Bolyukh*, newly appointed Deputy Head, Department of Preventive and Curative Care, MOH. After a brief conversation with Dr. Bolyukh, Telyukov invited him to join the work group in order to provide his judgment as a clinician on health care restructuring issues to be intertwined with the financing reform. Dr. Bolyukh set with the group for over two hours and actively participated in the discussions.

Telykov spent most of the remainder of his assignment working with the MOH-organized task force on health care financing reform.

FINDINGS

Railroad Health Insurance Experiment

Telyukov learnt from Dr. Schedriy that Mr. Durdinets, First Vice Prime-Minister made a decision ruling that disbandment of the industry-based health care systems is *unnecessary*. This apparently puts an end to a month-long stand-off between the Ministry of Health and the National Railroad Administration (NRA). As Dr. Eduard Gofman, Head, The NRA Medical Service, predicted back in October, an MOH new attempt to put the railroad health care facilities under its control has failed.

Dr. Schedriy also informed Telyukov that the National Railroad Administration (NRA) would undergo a significant reorganization by the end of 1996. The thrust of the reform would be to centralize the railroad management in Ukraine in order to prevent the system from technologic break-down and lead it through current economic crisis. According to Dr. Schedriy the situation aggravates steadily. Wage arrears keep growing. The crisis is exacerbated by persistent shortages of diesel fuel . This has brought the traffic to a complete halt on a number of railroad sections already.

Dr. Schedriy is confident that upcoming administrative change in the NRA will require redefinition of organizational and management patterns in the railroad health care system as well. Dr. Gofman's current priority is to preempt further uncertain developments by proposing to NRA viable ways of health care organization and financing. Dr. Schedriy is currently working on draft Concept Paper that would secure proper place for the railroad health care system within NRA new legal and administrative framework. Dr. Schedriy asked Telyukov to review this document in its first draft version so as to ascertain to what extent it complies with the goals and principles of the health reform as agreed upon for the Railroad Health Insurance Experiment (RRHIE).

Mr. Komkov, the Leading Software Designer, TMSU Insurance company had been working on adjusting the TMSU data base for casemix reimbursement system. This preliminary work was initiated by Telyukov and based on guidelines developed in Telyukov's earlier ZRP work. The system will perform step-down cost allocation to generate department-wide average costs and the loading ratios to load direct service costs -- already known -- with cost center overheads and facility overheads. Thus calculated total service costs will be aggregated into case costs. Cases will be grouped into DRG-type Clinical Cost Groups (CCGs). CCG rates will be estimated as weighted average costs of all cases, classified into given CCGs. Once costs of all CCGs are estimated, values will be transformed into points, thus creating a resource intensity relative value scale. Finally, relative points will be converted back into value amounts, using as multiplier a *base financing amount (BFA)* for each participating hospital. BFA may be defined as casemix-adjusted or, very likely, casemix-unadjusted average cost per case in a given hospital.

Telyukov's proposal is that the initial relative value scale (RVS) will be initially built at the Central Teaching Hospital of the Lviv Railroad Administration, a hub to TMSU and the main breeding site for main economic innovations to be tested through RRHIE. Such simplified approach -- *single* facility-based RVS -- is a trade-off to speed up the introduction of incentive-based payments to inpatient providers and allow for tight resource constraint, which at present disallows Mr. Komkov's group to integrate other facilities into the pilot. Several other hospitals will join the experiment right after the RVS is introduced and over the first year will generate facility-specific cost and utilization information which will be used to recalibrate the initial RVS.

The following list of cost descriptors has been selected by the counterparts or are the recommendation of Telyukov:

Cost Descriptor	*Status in the Current System of Clinical Reporting*
Principal diagnosis	Available -- ICD-9 codes
Comorbidities	Available up to two -- ICD-9 codes
Surgery	Presence or absence is reported; reference to Medical Economic Standards (MES) allows to identify the kind of surgical intervention
Intensive care component	Has been inserted in the patient discharge coding form, based on ZRP recommendation: "Yes" or "No" and the number of days
Age	Available
Gender	Available
Length of Stay	Available
Discharge status	Has been introduced in a slightly simplified form, based on ZRP recommendation. Three terms of discharge are currently distinguished: "Discharged", "Expired", "Walked out against medical indications". No special discharge status is built in for neonatals, patients who suffered burns or infarction.
Major disease category	To be introduced
Deflation	To be introduced: costs should be tracked down in dollar-equivalence terms; quarterly adjustments may be sufficient

Listed cost determinants will be entered into the data base retrospectively for 7,000 cases, discharged from the Central Teaching Hospital during 1995. The sample will be then analyzed statistically in order to estimate statistical relevance of particular cost descriptors. Those, whose explanatory power will be found insignificant, would be dropped from further reporting, thus leading to a streamlined approach to coding and case-grouping work. CCGs will be formed, based on that streamlined technology.

Apart from the above listed indicators, Telyukov asked Mr. Komkov to include in the input table -- primary data for multivariate analyses -- the following "synthetic" parameters, so far perceived by the counterparts as self-explanatory cost variation factors:

- *Disease Severity* -- I*st*, II*nd* and III*rd* category;
- *Form of Treatment* -- inpatient, outpatient, day hospital;
- *Type of Treatment* -- diagnostic, or curative care.

If further technical assistance is considered, one option would be for Telyukov to see if any of these factors may be quantified and built in the statistical model. It may be interesting to measure their contribution to the actual pattern of cost variation. In the meantime Telyukov asked Mr. Komkov to speak with clinicians to check if such factor as "Disease Severity" may be captured by the forth and fifth digits of the ICD-9-CM, plus the *Comorbidities and Complications* Factor. Telyukov consistently advises his counterparts to adhere to primary and, therefore, more objectively defined clinical criteria.

Telyukov provided Mr. Komkov with electronic copy of ICD-9-CM, translated into Russian earlier under ZRP, and formatted into transition key tables, showing correspondence between ICD-9-CM and ICD-9 code numbers and diagnosis titles. Also Telyukov shared with Mr. Komkov the List of Surgical Procedures from Vol.3 of ICD-9-CM in Russian. He emphasized that he would not like to push RRHIE towards adopting these sophisticates listings. However, clinicians might be willing to examine those, as a more accurate alternative to existing clinical classifications. At some point it would be interesting to get doctors' opinion on whether gains in accuracy of coding may be worth the pain of dealing with 5-digit codes and a whole new surgical classification. Mr. Komkov said he would examine potential advantages and disadvantages of these listings with senior clinical staff of the Central Teaching Hospital.

Mr. Komkov reported on the progress with coding. 3,000 medical histories were processed to date: procedures were carefully identified and coded along with the clinical parameters of the case. The pace of coding is 1,800 cases per month. This is too low to get all 7,000 cases coded by the end of 1996 as was initially planned.

Health Care Financing Legislation

Dr. Korotko informed Telyukov that parliamentary hearings on a Draft National Health Insurance Law would take place in December 1996 at the latest. It does not necessarily mean that MOH has a binding commitment to that time line. Most probably, Dr. Korotko considers the end of the year as an opportune time to push a health care reform act through the Supreme Rada and would like to speed up internal preparatory work at the Ministry accordingly. Deputy Minister's sense of timing comes primarily from the pace of legislative work on the main set of economic reform issues. Such pace is set by a group of people currently working on the reform legal package in the environs of Kiev under the guidance of the Financial and Banking Commission of the Supreme Rada and in close coordination with Harvard policy advisory group.

Dr. Korotko stated as another current priority: improving the system of cash subsidies to compensate the costs of pharmaceuticals to eligible populations. His subordinates are

working intensively on a draft government decree that would change the existing system from free access to drugs for war veterans, diabetic and certain other categories of patients, to prospectively paid cash allowance. The latter would enable eligible individuals to buy designated pharmaceuticals on their own money. At present, it is health care facilities who pay to the drug stores the cost of 'free' drugs. The system is dysfunctional in a variety of ways: (i) Retail drug suppliers are aware that polyclinic and hospitals run short on cash and therefore would not pay their bill on time. They, therefore, restrict availability of drugs for 'free' provision and switch them in all possible ways to consumers who pay at the counter. Citizens, who by law are entitled to priority access, feel disadvantaged. (ii) Moral hazard is widespread: people who are entitled to free drugs would usually overstock on them whenever they can buy them. Substantial amounts of drugs are being wasted by the households and misallocated to relatives who could pay. (iii) Health care providers are engaged in manipulative behavior as well: hospitals and polyclinics would buy drugs wholesale, allegedly, for free distribution to entitled patients, but would then charge retail price to non-eligible patients.

Telyukov and the health care financing task force organized by the MOH completed a seven page draft text based on writings and discussions previously done by Telyukov for the MOH of Ukraine, and with concurrent input from ZRP and USAID/Kiev technical staff. Most of the time was spent on discussions with the task force to encourage them to think of health care reform not just as a single-item agenda, focused on mandatory health insurance, but rather as a large range of issues relating to resource generation, resource allocation, and service delivery reforms. The consensus on such approach developed quickly and underlied concrete ideas and proposals. Over a several day period, the initial draft was edited into a much more concise version.

Dr. Korotko asked Telyukov to meet with Mr. *Nikolai Nagliy*, Director, *Economics of Health -- Northern Innovation, Ltd*. Mr. Nagliy came to Kiev from Murmansk, Northern Russia. He runs a small business, which developed a data base to account costs at the health care facilities, integrate them into territory-wide average costs and set reimbursement rates per service, patient discharge, etc. While in Kiev Mr. Nagliy stormed the Health Ministry of Ukraine for five consecutive days, trying to convince the MOH decision-making staff that he was offering the state of the art *health care reform technology*, equal to none in the former Soviet Union. Mr. Nagliy charges $100,000 for his product as first installment, which equals 20 percent of the total cost. Mr. Nagliy ran a demo for some of Dr. Korotko's staff and Telyukov. Telyukov found the system to be misrepresented: it is just a cost-accounting software product, reflecting one of a variety of approaches that may be used to calculate costs. The system ignores many other issues that should be addressed to turn it into a comprehensive management information system. As far as cost-accounting module is concerned, it is based on non-standard terminology, erroneous assumptions, and has no consistent economic underpinning. Primary data is overly detailed, while analytic value of the output information for financial management is diminished because of insufficient understanding of the nature of costs and how they correlate with the economic environment in which facilities operate. Rather than judging on specific technical features of the system and its configuration, Telyukov asked Mr. Nagliy two management-related questions: (i)

How much in terms of effort, time, and money it may cost per a medium-size hospital to implement and maintain the data base? (ii) What kind of service package the developers provide with the software? Mr. Nagliy seemed to have been caught by surprise by those questions.

Sharing his impressions with Dr. Korotko, Telyukov tried to avoid any categorical judgment of a particular software product. Instead he raised a more general issue. Whenever MOH feels it should shop for a new technology, be it for just pilot-testing or adaptation as a national standard, it should ascertain what is available on the NIS markets by publicly inviting vendors to participate in a competitive bid. Standard bidding procedures should be developed for technically oriented procurement, plus customization of terms should be allowed to gear prospective participants to MOH concrete needs. Also, the MOH experts should be taught the basic skills of evaluating competing proposals. ZdravReform might consider assistance in this area as an important issue. With aggressive marketing from manipulative vendors, scarce information, and little legal protection against deceptive practices, MOH and health care providers run a growing risk of wasteful spending on randomly picked goods and services.

Telyukov met with Dr. *Sergei Bolyukh,* Deputy Head, Department of Preventive and Curative Care, at his request. Dr. Bolyukh was quite outspoken in expressing his concern that the Ministry remains undecided about the reforms, with resistant attitudes still dominating the top echelon of policymakers. Dr. Bolyukh complained that he agreed to work at the Ministry because he thought his job would be to promote reforms: at this point, however, five months after he took office, he feels alienated and out of the reform business. There is no strategic thinking around: everybody is overwhelmed with daily bureaucratic routine. On a more specific score Dr. Bolyukh asked for technical assistance in assessing economic implications of alternative options of developing primary care. Telyukov explained that such assistance might be contingent upon the overall prospects for the Zdrav*Reform* Program and the list of priorities that would be worked out, should the project gets an extension. Answering Dr. Bolyukh's substantive questions, Telyukov proposed basic lines of economic and administrative work, inherent in creating family practices and strengthening their role in the continuum of service delivery. Dr. Bolyukh expressed strong willingness to establish closer cooperation with the ZRP economic component. He praised and emphasized importance of the conceptual guidance that the ZRP had been providing to the MOH economic service, suggesting that Dr. Korotko is worth being supported as the most consistent proponent of reforms at the ministry.

Telyukov met with *Dr. Taisiya Loboda*, Head, Department of Preventive and Curative Care. This meeting took place after Dr. Loboda expressed interest in meeting with Telyukov during her previous day conversation with Dr. Victor Omelchenko of the ZRP/Kiev office. The meeting took place at the end of a pre-holiday day and could not go far beyond introductory conversation and some general discussion relating to the role of the MOH clinical departments in the reform design and implementation process. Dr. Loboda said she would like to keep in closer touch with ZRP activities, including Telyukov's current activities at the MOH.

Telyukov met with *Mr. Nikolay Belotelov*, Head, MOH Law Department. The purpose was to estimate the scope of his involvement in health care reform legislative process. Legal expertise must be important in reconciling the MOH regulatory initiatives with provisions of the Constitution and the Civil Code of Ukraine. Mr. Belotelov informed Telyukov that he usually attended meetings at the Minister's office, whenever those related to legal innovation. However, he did not play any active role so far in appraising specific initiatives or documents. Concurrent with Telyukov's own impression was Mr. Belotelov's information that there is no tradition at the MOH of conducting legal review of the Minister's writings and verbal interviews intended for publication in the press.

Telyukov did not share his concerns with the lawyer, however, there must be some way at this time to bring up to the Minister's attention the issue of public relations and legal consistency as regards his appearances in the media. From reading Minister Serdiyuk's recent interviews Telyukov could conclude that the Minister likes to wage unsubstantiated attacks on other government agencies, particularly social insurance foundations and some of the Ministries, operating their own health care provider networks. This may result in strong and coordinated opposition to his reform activities, even before they start. Hostilities with other branches of power do not set the most productive environment for the MOH reform campaign. Likewise, Mr. Serdyuk's idea of mandatory inclusion of foreign citizens in Ukraine's national health insurance may create strain in its relations with the rest of the world.

Telyukov was introduced by Ms. Podgornaya to Dr. Inna Demchenko, a newly appointed staff advisor to Minister Serdyuk. A brief conversation occurred rather spontaneously. Dr. Demchenko came to MOH from Academia. She is a biochemist by her original training, with substantial experience of teaching in public health. She expressed interest in the ZRP activities and willingness to read some of the conceptual papers, submitted to MOH lately. Telyukov provided her with one of his texts and volunteered to meet with Dr. Demchenko at her convenience to answer her questions and discuss a broader set of issues that may come into focus of Dr. Demchenko's attention.

Dr. Korotko informed Telyukov of the next steps with the reform legislation. Those would be preparation of the official MOH Draft of the health insurance law and financial modeling to calculate premium rates for employers, amount of budgetary allocations to the health care sector, scope of user charges, cost savings under specific scenarios of pro-efficiency restructuring of the health care system. Deputy Minister asked Telyukov to prepare a request for information to conduct such analyses.

RECOMMENDATIONS

Railroad Health Insurance Experiment

ZRP and USAID need to determine whether the RRHIE experiment should continue as part of the ZRP technical assistance program. This report represents the last in a series of assignments to complete an economic and legal assessment of the RRHIE experiment. At this point, no further work is planned. As mentioned in earlier reports, RRHIE has the potential to test several aspects of health insurance reform and system restructuring. On the other hand, the RRHIE is a unique environment (politically and economically) which may mean that lessons learned are not easily replicable to other government settings. The reader is referred to the RRHIE summary economic and legal appraisal report written by Telyukov in May/June 1996 for a full discussion of the issues to be considered in making a decision about future collaboration with the RRHIE.

If the ZRP project is to develop a package of technical assistance activities for the RRHIE, one component might be to develop a comprehensive plan to test new payment methods, including case-base payment. Some preliminary work has begun in this regard, although a full review would be necessary by ZRP and USAID of what approach should be followed to develop and implement case-based payment, including what tasks would be required, how they would be accomplished, and what composition of technical consultants would be needed to design and implement the experiment.

Some direct follow-up to the Telyukov proposed approach would be to:

1. Create a locally-adapted clinical coding system based on suggested cost descriptors;
2. Speed up the coding process by hiring a temporary workforce;
3. Roll-out the Telyukov cost allocation work to other RRHIE participating hospitals so that several facilities could go into a new system of management accounting, rate calculation, and cost reimbursement on January 1, 1997.

Health Care Financing Legislation

1. The MOH should continue to build and strengthen the panel of experts or task force working on health care financing and system reform legislation. During the start-up phase, ZRP can assist with coordinating, and facilitating group discussions and providing technical assistance, but once established, this panel should become institutionalized as a think tank that can provide the MOH with informed responses to health care reform issues as they arise.

2. The MOH should work to bridge the gap between the health services and health economics units within the Ministry. Health care restructuring issues are clearly closely intertwined with financing reform.

3. The MOH should continue develop reform in health care finance, not just as a single-item agenda of mandatory health insurance; rather, it should cover a large range of issues relating to resource generation, resource allocation and service delivery reforms.

4. The MOH should consider setting up a competitive bid process for selecting new computer technology. Standard bidding procedures should be developed for technically oriented procurement, plus customization of terms should be allowed to gear prospective participants to MOH concrete needs. MOH experts should be taught the basic skills of evaluating competing proposals.

5. The MOH (Dr. Bolukh) requested ZRP to assist with the development of the economic and administrative framework for family medicine.

6. The MOH (Dr. Korotko) requested ZRP to assist with conducting a financial feasibility study for the proposed health care insurance law including the calculation of: premium rates for employers, amount of budgetary allocations to the health sector, scope of user charges, cost savings under specific scenarios of restructuring of the health care system.

CONTACTS

Korotko, Alexandr Shimonovich.
Deputy Minister, MOH, phone 380-44-293-00-56

Loboda, Taisiya, Vladimirovna.
Head, Main Administration of Medical Care for Adult Population, MOH
293-16-55

Bolyukh, Sergei Afanasyevich.
Deputy Head, Main Administration of Medical Care for Adult Population, MOH
293-80-51

Podgornaya, Lyudmila Mikhailovna.
Head, Department of Economic Innovation and Health Insurance, MOH
work phone unavailable, home phone: 547-40-83

Kovzharova, Ella Vladimirovna.
Main Expert, Department of Labor and Salary Planning, MOH
home phone; 271-24-14

Demchenko, Inna Borisovna.
Advisor to the Health Minister, 293-74-40

Belotelov, Nikolay Gueorgiyevich.
Head, Law Department, MOH
293-72-14

Prof. Lekhan, Valeriya, Mikitichna
Head, Department of Social Hygiene, Health Management and Organization.
Dnepropetrovsk Academy of Medicine
office 38-0562-417311 fax: 38-0562-46-41-91

Mr Schedriy, Petro Vladimirovich
Director, TransMedStrakh-Ukraine Stockholding Company

Mr. Komkov, Artur.
Leading Software Developer, TransMedStrakh-Ukraine Stockholding Company

Mr. Rudiy, Vladimir, Miroslavovich.
Executive Secretary, Health Care Maternity and Childhood Commission.
Supreme Rada of Ukraine 296-86-55; 295-22-70

DAILY LOG

On ***November 3rd***, Telyukov contacted Dr. Petro Schedriy, Director, *Transmedistrakh--Ukraine* (TMSU) Stockholding Insurance Company by phone. Dr. Schedriy was suffering from pneumonia and had to stay in Lviv for the week. Telyukov and Schedriy discussed new developments in the RRHIE.

On ***November 4th*** Telyukov met with Dr. Korotko, Deputy Health Minister of Ukraine in Charge of the Economic Innovation and Health Insurance Reform.

On ***November 5th*** Telyukov received an urgent request from Dr. Korotko to work for a day and a half with his key staff on the financing section of the Conceptual Outline of Health Care Reform. He also had a telephone conversation with Prof. *Victoria Lekhan*, Dnepropetrovsk and agreed on her participation in the would be national health care reform think tank. Prof. Lekhan will come to Kiev on November 11th for a start-up meeting.

On ***November 6th*** Telyukov had a number of meetings with the MOH senior executives including Dr. Bolukh, Dr. Loboda, Dr. Belotelov, Ms Podgornaya, Ms. Kovzharova, and Dr. Korotko.

On ***November 7th*** Telyukov spent most of the day working with Artur Komkov, Leading Software Designer, TransMedStrakh--Ukraine (TMSU) Insurance Company.

On ***November 8-10th*** Telyukov worked largely by himself, reading documents and dealing with multiple requests received from his MOH and RRHIE counterparts.

The second week (Nov. 11-15 th) was spent on a team-work on draft health insurance law. The document is enclosed with this report.

Appendix A
UKRAINIAN LAW ON FINANCING OF HEALTH CARE AND HEALTH INSURANCE*

The current law identifies sources of financing of health care, guidelines and the order of resource utilization, as well as related legal relationship.

GENERAL REGULATIONS

In the context of the current law, health care -- is the complex of types of activities, carried out by services and facilities that have the license for medical practice issued by the government.

FORMATION OF HEALTH CARE FINANCIAL RESOURCES

Total health care costs are established basing on the tempo of development of Ukrainian economy according to the increase (decrease) of National Gross Product (NGP). Total health care costs from all the sources of financing are planned for the coming year taking into account NGP increase (decrease) through the last year. With the NGP decrease over the last year, total health care costs for the year planned are not reduced in compared prices. With the NGP increase over the base year, total heath care costs for the reported year increase 1.5% per each NGP increase percent in compared prices. Such a distribution is valid until the heath care portion of NGP reaches 8%.

Comparability of prices used as a basis for calculations of total heath care costs, is made through the re-calculation of costs for the planned year considering the official inflation level.

Total health care costs are set according to the methodology of national health care billing. National health care billing system is developed using international experience and Ukrainian conditions. Reporting forms and standards, necessary for the development of the national health care accounts, are approved of by the Cabinet of Ministers Decrees and become a part of national statistic reporting system.

National health costs as a part of the total health costs is set for the first two years at the lowest of 80% with gradual reduction down to 60%.

Health care payments from the national budget and mandatory health insurance fund are planned and allocated on territorial basis with differentiated per capita rate. Differentiated per capita rate is calculated basing on social and demographic stratification of the population, morbidity and mortality rates and levels, and to minor extent, on resource indicators and facility network. The differentiated per capita rate formula is developed by the MOH and is approved by the Cabinet of Ministers.

Differentiated per capita rate is mandatory when:

The territorial MMI Fund is reasoning contribution rates for MMI as related in the paragraph ___;

The National MMI Fund averages costs throughout the territories as related in paragraphs ___;

The government is subsidizing economically not well-off territories (Reference to the Law on Budget System) to average conditions and delivery of health care to the population.

* Translated from Russian

BUDGET FINANCING OF HEALTH CARE

Health care budget financing is allocated for the following purposes:

Specific medical and preventive care programs, types of health services of special social importance, including immunization, financial donations for drugs aimed at social benefit groups, measures on epidemiological disasters.

Subsidies for economically not well-off territories (Reference to the Law on Budget System) to average conditions and delivery of health care.

MMI contributions for the population categories, identified in the article ___;

State reserve for high cost reimbursement in the system of MMI in the cases of complicated and long term diseases.

Specific capital investments.

Specific donations health personnel training and re-training.

Financing of medical and biological research and studies on tender basis.

Financing of informational and managerial provision of the state-owned part of health care.

Ministry of Health of Ukraine, Ministry of Health of the Autonomic Republic of Crimea, Oblast Health Administrations, Kiev and Sevastopol City Health Administrations, Rayon and City Health Administrations are the bodies authorized to allocate financing for the purposes stated in the paragraphs ___. Ministry of Disaster and Calamities is the fundholder for the paragraph __.

SOCIAL (MANDATORY) MEDICAL INSURANCE

Definition

Mandatory medical insurance (MMI) is a constituent part of the social insurance system. MMI -- is the legal relationship system providing the citizens with equal opportunities in getting health insurance within the financing of national and territorial MMI funds.

Principles

MMI is based on the following principles:

Full coverage of MMI is provided by the _____ of insurance for employed and self-employed citizens, responsibility of the state for the insurance of all unemployed, and the right of those involved into entrepreneurial and artistic activities to participate in the MMI.

Social solidarity presumes provision of insurance and health services for all categories of citizens on conditions that do not depend on their health status and income.

Economic effectiveness and clinical appropriateness of care provided by the MMI system.

State responsibility for the stability of MMI system.

Participants

Insured, insurers, insurance bodies and health facilities are the participants of MMI legal relationship.

In terms of MMI, *insured* are the bodies subject to mandatory and voluntary inclusion to MMI.

Following categories of citizens are subject to mandatory inclusion to MMI:

1) citizens employed on contract basis at enterprises, organizations, facilities, disregarding their form of ownership, and those employed by other citizens;
2) members of collective enterprises;
3) citizens of Ukraine working at foreign diplomatic representative offices and counseling organizations of Ukraine;
4) people elected to electoral positions to the governmental bodies and local administrations and self-governance bodies, and those elected to non-governmental organizations and getting salaries for that;
5) people doing professional training and re-training without continuing work;
6) people studying at higher educational establishments (day courses) and at technical schools, clinical residents, and post-graduate students, doctorates;
7) people doing military service at Ukrainian Army, National Guards of Ukraine, Security Service of Ukraine, Frontier Guards, Internal and Escort Forces, Civil Defense of Ukraine, Ukrainian Police, other military formations established according to the Ukrainian Law;
8) people, whose contract is broken as a result of the changes made in the organization of production and labor, getting average monthly salary at the previous place of work for the employment period;
9) unemployed, getting welfare;
10) people on maternity leave;
11) unemployed, capable people, taking care of a disabled person of the 1st group or a disabled child aged until 16, as well as taking care of a retired person, who according to the medical expertise, needs constant outside care;
12) self-employed:
    members of artistic unions,
    artists that are not members of artistic unions,
    self-employed entrepreneurs that do not provide employment for other people;
13) retired;
14) people doing alternative, non-military service;
15) children and adolescents (aged 0 - 16);
16) disabled people.

Supplements to the list of the categories of citizens subject to the MMI can be made through legislative documents of Ukraine.
Ukrainian citizens working abroad that are not insured in the country of their location, are subject to MMI in Ukraine.
Foreigners and people without citizenship temporarily or permanently living in Ukraine are subject to MMI .....

The following categories of people are subject to voluntary inclusion to MMI:
Citizens that have not been included into the given above list of population categories subject to mandatory insurance, can be insured by MMI system on voluntary basis with the same conditions.

---------- (Article 16) ----------

According to MMI, the following are insurance bodies:

---------- (Article 16-17) ----------

According to MMI, the insurers are National and territorial MMI funds.

Subject of insurance and an insurance case

MMI provides the insurance of costs for health care associated with preventive care, diagnostics, treatment, and rehabilitation of general diseases, household injuries, as well as pregnancy and maternity care.

MMI does not provide compensation of drug costs.

According to MMI system, an insurance case is the case of medical care provided at licensed health facilities due to the conditions stated in the paragraph ____ (see the paragraph above).

Volume of insurance reimbursement

Volume of health care financing under MMI is defined by the revenues of MMI funds taking into account their planned volume and utilization.

Planned volume of MMI revenues is defined by MMI contribution rates. Initial rates are set for enterprises and local administrations basing on average per capita financing and the level of care, provided by medical facilities of state and communal forms of ownership in the pre-crisis year of 1990. The rates are adjusted on annual basis to provide the increase of costs in the MMI system proportionally to the increase of total costs for health care as defines in paragraphs ___ (see General Regulations)

Base MMI contribution rates are set by the Supreme Rada of Ukraine at the same time when approving the national budget. The Supreme Rada of the Autonomic Republic of Crimea and local administrations set the MMI contribution rates for specific regions and areas at the level that is not lower than the base contribution rates.

In the case of incomplete collection of MMI contributions, general level of health care financing is reduced for the amount of payment deficit. The deficit is allocated to the types of health facilities and kinds of care provided due to the priorities of a specific area identified by the local administrations.

Limitation of insurance reimbursement

Costs of the health care provided without a primary care physician's referral, or at the facilities that do not have a contract with MMI fund, are reimbursed in the amount of 80% of the rate that is used for payment in the MMI system. This condition is not due to the urgent care.

Costs of the health services provided as a result of an intended offense or a crime are reimbursed by the insured.

Co-ordination of insurance reimbursement

A person insured by MMI is obliged to inform MMI about the existence of another source of insurance reimbursement. MMI insurance reimbursements are made at the amount that is not covered by other types of insurance reimbursement.

Sources of financing

MMI contributions are coming from the following sources and are exempted in the following order:

The main sources of territorial MMI fund financing are the following:

Insurance contributions of employers for the people listed in the article ___, paragraphs 1-5, 8
Insurance contributions of people listed in the article ___, paragraphs 1-6, 12
Insurance contributions from rayon (city) budgets for unemployed citizens listed in the article ___, paragraphs 10, 11, 14
Insurance contributions from the national budget for the citizens listed in the article ___, paragraph 7
Insurance contributions from the Pension Fund for the retired people
Insurance contributions from the Employment Fund (Insurance Fund in case of unemployment) -- for unemployed
Specific subsidies from local budget
Other intakes that are not forbidden according to the current law.

The order of making payments

MMI contributions are made in the following order:

a) contributions for employed -- as a percentage of payroll;

b) contributions for other citizens -- fixed sum of money at the amount of average per capita health care costs in a given territory;

c) 90% of insurance contribution is paid by the insurance body; 10% -- by the insured;

d) an insured is exempted from paying a contribution if his total family income per family member does not exceed three income minimums, that is not subject to income tax;

e) in the case if an insured is exempted from paying a contribution, the insurance body pays 100% of the contribution;

f) on the paragraphs a) - e), MMI contributions are collected from the incomes that do not exceed 10-fold average salary in national economy for the last year;

g) on the paragraphs a) - e), MMI contributions are retained or paid simultaneously with the income tax;

h) employers' MMI contributions are paid in the order set for other charges to the payroll fund.

The enterprises, admitted bankruptcy, continue paying MMI insurance contributions until they terminate paying all current bills. Successors or liquidation committees of the enterprises admitted to be bankrupts, first of all discharge the debt on MMI contribution, using liquidation revenue or successors funds.

Occupational risk insurance

Health care cost insurance in the case of a professional disease or injury is mandatory for all people employed or contracted for a period of time to perform a specific job.

MMI on occupational risks is done from the employer's funds.

The contribution rate is set by a insurer and defined by the level of occupational morbidity or traumatism. The list of diseases attributed to as occupational diseases is set by the Cabinet of Ministers of Ukraine.

MMI on occupational risks is performed by specialized departments of territorial MMI funds.

The status and functions of an insurer

Territorial MMI funds are established in the Autonomic Republic of Crimea, the cities of Kiev, Sevastopol, and all Oblasts of Ukraine.

Territorial MMI funs -- is a self-governing non-commercial organization with the following main types of activities: registration of population for inclusion into MMI; accumulation of insurance contributions; accreditation of health facilities for participating in MMI system; health care rate formation under MMI system; signing and execution of contracts with health facilities, including payment for health services for insured population; control of quality, clinical sufficiency and appropriateness of health care; informational and methodological support of health facility network structural reorganization and economic rationalization of medical facilities; dissemination of modern financial management techniques in health care; administration of experiments on improving efficiency of health care; prediction of demand for health resources to cover medical care costs under MMI system.

The financing of territorial MMI fund operational activities should not exceed 3% of collected funds.

The order of formation, administration bodies, operational and financial issues, reporting/ control forms and order of MMI fund activities are identified by the Regulations on Territorial MMI funds, that is approved by the Cabinet of Ministers of Ukraine.

National MMI fund

National MMI fund is formed by Territorial MMI funds with the purpose of: a) provision of financial stability and averaging of financial abilities of Territorial MMI systems; b) informational and methodological provision of Territorial MMI fund activities; c) development and adjustment of MMI contribution rates; d) representation on behalf of Territorial MMI funds at governmental, non-governmental, and international organizations.

The contributions for National MMI fund activities are set at the amount of 10% of MMI contributions and are mandatory.

Financing of operational activities of National MMI fund should not exceed 3% of the funding received.

The order of formation, administration bodies, operational and financial issues, reporting/ control forms and order of National MMI fund activities are identified by the General Meeting of Territorial MMI funds representatives.

MMI Card

MMI Card is given to each insured under MMI and is valid on the whole territory of Ukraine.

The issue of a MMI Card tally in the case when the original card was lost is done for charge.

The sample of the card, the order of filling it in, handing out and utilization is set by National MMI fund.

MMI insured have to present the MMI Card each time they turn for health services. Absence of the Card is a reason for denial in providing medical services, except urgent care.

VOLUNTARY MEDICAL INSURANCE

Voluntary Medical Insurance (VMI) supplements MMI and provides coverage of the health care costs over the volume and level set under MMI system.

VMI is provided on commercial basis by insurance companies that have a license for this kind of insurance.

The order and conditions of VMI are regulated by the Law of Ukraine on Insurance.

VMI health services are oriented on the non-governmental medical facilities, including formation of health facilities owned by insurance companies, lease and privatizing of state-owned and communal medical facilities.

Lease and privatizing of state-owned and communal medical facilities is done with the permission of local administration.

CITIZENS' PERSONAL ASSETS

Citizens' personal assets are attracted in the following cases:

Contributions for VMI;
In the case of partial reimbursement (the article on limitations on insurance reimbursement);
When not participating or refusing to participate in MMI system;
When covering medicine and medical supplies costs, that are not regulated by the conditions of MMI and VMI;
In the case of partial reimbursement for social medical services and health care for patients in the terminal stage of disease.

HEALTH CARE FACILITIES

Health facilities -- are the facilities, organizations, or enterprises -- including individual and group physicians' practices -- of all forms of ownership and economy that have a license for medical practice and sale of drugs and medical supplies.

Licensing of health facilities in done by the Council of Ministers of the Autonomic Republic of Crimea, Oblast Administrations, Kiev and Sevastopol City Administrations. Licensing order and conditions are set by the Cabinet of Ministers of Ukraine.

Health facilities have a legal entity status and all rights of operational and economic autonomy, including their own bank account, the right to form their staffing schedule and workload norms, the right to develop contractual relationship with health care customers, other medical and non-medical organizations and enterprises.

FINANCING OF HEALTH FACILITIES

Health facilities are financed basing on the contracts with the budgetary, insurance and other fundholders.

The contract identifies financing methods, including:

Per capita financing of assigned population: financing is transferred to a primary care facility in the volume sufficient to provide all kinds of care that, according to the contract, are provided and controlled by the facility. The facility is authorized to utilize the financing for its own activities as well as for the activities of its subcontractors. Savings generated without any effect on the quality of health services are not exempted and are utilized for the primary care facility development. Overspending of the financing provided is not reimbursed except if its objective reasons are recognized by the financing party.

Fee-for-service financing of outpatient care: the health services are paid for according to the service rates. Classification and price lists are developed by Territorial MMI funds.

Financing of inpatient care: the financing is allocated for the number of treated patients on the rates that are set as average for certain territory basing on clinical complexity and resource intensity.

According to the identified financing methods (see paragraphs ___), basic financing volume is allocated prospectively with the following payment based on qualitative and quantitative indicators of provided health services that are tracked quarterly.

Health facilities acquire and utilize resources according to the global budgeting method, i.e. financing is not allocated to specific line-items and is utilized disregarding weighted spending limits.

TAX EXEMPTIONS

Enterprise payments to VMI and on contracts with health facilities are exempted from taxes under condition that the enterprise is not in debt for paying MMI contributions.

Physical entities are exempted from taxes concerning insurance and direct payments for health care that is done from the sum exceeding 25% difference between the annual income per family member and the level of poverty.

Medical facilities, except those listed in the paragraph __ (see next paragraph), are exempted from the tax on capital and revenues from health care delivery.

Medical facilities are exempted from the tax on capital and revenues from non-medical activities, at the amount that does not exceed 50% of gross revenue.

Organizations, that have a license for the sale of drugs and medical supplies, are exempted from the tax on capital and revenues concerning the revenues from drug and medical supplies sale according to MMI lists.

MMI funds are exempted from the taxes on capital and revenues from basic kinds of economic activities.

CITIZENS RIGHTS

Citizens insured under MMI have the right of free assignment to a primary care physician. The assignment is done once a year over the period of *free assignment* that lasts 30 days.

QUALITY CONTROL

Quality control of health services is undertaken preventively -- within accreditation process -- and operatively, manly basing on clinical outputs, appropriateness, and sufficiency.

Appendix B

REMARKS
to the Draft of the Law on Medical Insurance
by N.Markovska, Supreme Rada of Ukraine Deputy

GENERAL EVALUATION

Terminological and notional system of the Draft does not meet national and international standards, experience and practice that have been established in economics, health care administration and insurance practices. Suggested approaches do not form an internally universal system, as they are not based on solid concept and logic. They cannot be classified into any of existing health insurance systems.

This document does not present a form of a Law Draft. There is neither a subject nor legal regulation mechanism.

Having no subject in its content and being inadequate regarding the form, the Draft is not a valid topic for the further discussion.

At the same time, the Draft theses concerning tax exemption deserve positive evaluation.

Further-mentioned there are some considerations of objective criticism concerning specific document theses.

INSURANCE PRINCIPLES

Mandatory insurance. Mandatory character of the health insurance seem to be a groundless statement for two reasons. First, the main characteristics of MMI are not present in the document. Second, the development of the MMI is suggested to be postponed to indefinite future and regulated legal acts. Thus, articles 3, 4, 5, 7, 8, 9 and 11 refer the MMI issues to the affairs of the Cabinet of Ministers. This approach contradicts article 92 of the Constitution of Ukraine declaring that regulation basis in health care is defined exclusively by laws of Ukraine. Besides, in the current Draft, the MMI system is placed in the position subordinate to the VMI.

Contribution recoverability. Article 2 sets the principle of recoverability of the resources not utilized for insurance reimbursement. This is a violation of the most critical principle of social insurance -- the principle social solidarity. The return of not spent resources to relatively healthy insured pool will make impossible using them for the health services to relatively sick pool. Account individualization is adequate to a refusal to insure those who need it most.

Recoverable and accumulative feature of insurance. Article 2 expects that a part of insurance contributions which should be spent in the future, for age-determined diseases, would be invested and a part of the income obtained would return to the insured. This approach is doubtful on two accounts. First, existing methods of predicting diseases and health indicators have probability character. The age-determined probability at the per capita level can be hardly tracked which contradicts to Article 2. There is no empirical basis in the country which would help to set the rate of insurance contribution to be reserved depending on the social and demographic indicators of the insured pool. Second, there is no well established financial market and clear prospects of their development that does not allow to name financial tools to use for investment of reserved insurance contributions; let alone more or less precise estimation of revenues. There is a concern that recoverable and accumulative VMI can become another financial pyramid. Moreover, the Draft does not suggest any specific tools of investment regulation and the protection of insured interests.

LEGAL RELATIONSHIP PARTIES UNDER MEDICAL INSURANCE

Article 3 identifies not subjects but participants of legal relationship under health insurance as insured -- are objects, but not subjects.

CONDITIONS OF HEALTH CARE DELIVERY

Sources of Health Care

Article 4 identifies that under VMI, health services are provided by state owned and communal medical facilities. As the payments from the population under VMI are inevitable -- Article 2, in particular expects that physical entities are one of the insurers under VMI -- the above noted thesis of article 4 contradicts article 49 of the Constitution of Ukraine. Health care in public and communal facility network cannot be paid.

NEW CONCEPTS

The draft authors introduce the notion of *basic health level* (Article 5). Suggested definition is vague: it is ambiguous and can be estimated neither on epidemiological nor on socioeconomic account.

At the same time, basic health level notion is initial for the definition of insurance risks and VMI program, placing the system of concepts used in the draft in unstable position.

Economic mechanism of insurance contribution collection

Article 11 establishes the employers right to include VMI contributions into net cost at the amount of three minimum incomes. Under conditions of absence of free price formation, and the prices are subsidized in bulk and without any succession, VMI contributions for the benefit of specific enterprises will be transferred to all consumers of products and services and a general taxpayer through subsidies, as the subsidies are financed from general national budget. Such an approach contradicts the essence of market reforms in Ukraine. From formal point of view, such an approach contradicts the Law of Ukraine on Taxing Enterprise Profits, that allows to attribute only MMI expenses to the net cost.

QUESTIONS TO THE AUTHORS OF THE DRAFT

1. The clarification of Article 10 thesis about cost reimbursement under VMI for improving living conditions by medical indicators.

2. How should be interpreted the Article 13 thesis on insurance body right to appoint citizens or legal entities for receiving health care?

3. It is unclear, why the health facility is not eligible of choice between participation or not participation in the medical insurance system. According to Article 22, health facilities are not eligible to deny an insurer in making a contract on health care provision for insured.

4. The advisability of local administration involvement into development and realization of VMI plans should be explained.

Appendix C

INPUT TO THE MOH DRAFT HEALTH CARE REFORM CONCEPT by the Task Force (Podgornaya, Kovzharova, Lehan, Prodanchuk, Telyukov), November 1996*

CHAPTER "HEALTH CARE FINANCING MECHANISMS"

General Statements

Neither state without market, nor market without state is in condition to change health care for better. It is required to work thoroughly at developing health care self-regulating mechanisms rather than to run from "overall and free" to "overall paid" extremes. The aim of such effort is to improve accessibility and quality of care, increase its effectiveness and attain financial stability in health care.

Three task groups intercept achieving the above-mentioned aims:

- finding additional resources for health care
- changing spending mechanisms in health care
- restructuring health care delivery mechanisms

- **Additional Financing**

It is necessary to use all opportunities to increase spending on health care both out of public budget and additional financial sources.

For successful functioning of health care it is necessary to provide financial protection of the industry. Resources allocated for the industry need to be bonded to the rates and increase of national gross product so that the aggregate spending on health care would gradually grow up to 8%. We presume that Ukraine being the country with average level of economic development spends on health considerably lower share than other developing countries on an average.

Budget allocations within the current network

In order to bring health care out of crisis it is relevant to concentrate direct budget allocations on the following programs (under condition that the volume of resources allocated for health is adequate):

1. Health programs and health services of particular social priority including immunization, donations for medication for social benefit groups, urgent epidemic situations.
2. Earmarked expenditures on disaster and accident works
3. Balancing and stabilizing transfers to economically not well-off areas.
4. Public reserve fund for reimbursement of high costs caused by complicated and long-term cases within the mandatory health insurance pool.
5. Financing mandatory health insurance Fund on primary stages of its activities.
6. Earmarked expenditures for capital investment.

* Translated from Russian

7. Earmarked donations in the system of training and retraining of medical staff as well as to the most progressive clinical and biological research programs.

Taxing "harmful habits"

This could be cigarette and alcohol tax.
A possible application variant includes introduction of earmarked tax on health care by addressed reallocation of the part of existing excise tax or its supplement that creates stable inflow of resources and apparently can promote healthy life style.

Mandatory Medical Insurance

Mandatory medical insurance (MMI) system is possible to be put into practice if the following specific problems are decided:

1. Introduction of the earmarked tax for mandatory health insurance: on the employees' salary for working population, on employers for employed, on local administrations for the major part of unemployed, from self-employed as regulated by self-insurance, from the Pension Fund for pensioners, from the Employment Fund for the major part of jobless, from the Chornobyl Fund for suffered from Chornobyl disaster.

2. Creation of the MMI territory systems. MMI assets are supposed to be accumulated in the MMI funds.

3. Clarification of the MMI fund status, functions, conditions and relation principles between health facilities.

Insurance against occupational diseases and injuries

It should be comprehensible and mandatory. The Employment of not insured work force should be prohibited by law. The responsibility for reimbursement of occupational hazard to employee's health, including the cost of health services provided to him, is delegated to employer. Consequently, there will be two parallel systems of MMI: first, *insurance of general medical risks -- MMI,* second, *insurance of occupational medical risks.* The first system have the sole rate promoting principles of social solidarity (the rich pays for the poor, healthy one for the sick). It is also possible introduce minor differentiation of the rate depending mainly on the age/sex indicators. The latter system includes age/sex weighted rate in regard to risk factors existing in specific industries and specific enterprises. Insurance of occupational risks based on the actuarial principles will be the liability of specialized departments of MMI Funds or commercial insurance companies/

Voluntary Medical Insurance

In general, voluntary medical insurance plays assisting role:

1. If GNP share from public budget and mandatory medical insurance for health care is lower than 6-8% then the rest of the necessary resources is coming trough the system of voluntary medical insurance.

2. Attracting financing of financially well-off enterprises and citizens, both Ukrainian and foreign.

3. Encouraging voluntary insurance to develop its own physical plant: promoting insurers for construction and capital repairs of medical facilities; privatization of excessive capacities of public health facilities under permission of health authorities; organization of new physician practices and health centers (which allows avoiding possibility of utilizing public resources for provision of health care to patient with VMI);

4. Development of customers' cooperative in health care in the form of collective self-insurance of population.

Citizens' Personal Assets

Assets of the population should not be considered as a remedy against deficit of financing in health care. As an alternative source they can be used in the following form:

1. Co-insurance for extended MMI programs.
2. Contributions for VMI.
3. Health services deductible.
4. Partial insurance reimbursement if actual annual cost amount exceeds fixed one for specific services.
5. Full paid services for the patients who consciously rejected any type of insurance.

- **Spending Mechanisms**

New payment methods play key role in restructuring health care which create strong incentives for health employees to utilize resources more effectively, in particular to intensify clinical process, to increase utilization of facility capacities, to restructure health network towards outpatient and primary care.

Current method of line-item budgeting based on the inpatient bed/day and outpatient visit norms is not valid any more. Method retreat has been already started and should be accelerated. The following obstacles are waiting ahead:

1. Change in payment methods of health facilities: financing should be made retrospectively (inpatient units are reimbursed per treated patient, outpatient -- per episode of care or service).

2. Providing the previously existed and newly established health facilities and physician practices with full legal and economic autonomy. Particularly:
- every health organization has its own bank account;
- line-item budgeting is canceled;
- norm staffing schedule and performance intensity norms are canceled;
- every health care provider is entitled to unlimited rights of settling direct contract relations with other health and non-health facilities and organizations.

3. Necessity to make tax exemption on income of health facilities and practices receiving direct budget allocations, dealing with mandatory and voluntary insurance; to set considerable tax exemptions on other income categories, including non-health activities.

4. Creation of favorable (including financial) environment for the activity of free-standing physician practices like family physician group, obstetrician/internist groups, family physician ambulatories, etc. Encouraging free-standing health care providers stepping into the market-- specialty physician practices, different profile diagnostic centers, nursing facilities and hospices which are able to satisfy demand for deficit services and provide care at lower costs.

5. Gradual introduction of financing per capita assigned with shift of resources to general physician practices (GPP). GPPs become partial or full fundholders of per capita financing. Fundholding and per capita financing on all levels of health care provides possibility to introduce transparent system of cost-containment economic incentives and leads, eventually, to the shift of emphases on outpatient care.

6. Introduction of mechanisms which allow the population to have free assignment to the primary care units. Annual budget for GGP is allocated proportionally to the amount of assigned pool and, thus, one of the most critical principles of market competition will be implemented: " Money follows the patient".

7. Prediction of gradual and manifold transition to family physician practice and fundholding.

8. Gradual integration of industry and territory systems of financing and health care provision.

9. Informational and management health system update, introduction of up-to-date cost accounting and price-setting methods.

10. Quality control system update, improvement of licensing process. The quality care should be estimated by clinical outputs rather than by clinical process. The quality control should also be focused on the adequacy of clinical decision about specialty referrals and hospitalization/discharge permissions.

11. Agreement about division of state and market functions.*State* regulates market, performs specific public health programs, invests development of all types of care which are not covered by the market self-regulation mechanisms. Market being an aggregate system of regulated competition mechanisms and economic incentives provides all or almost all types of personal health care. The major characters of the action should have incentives which would shove them to introduce desirable innovations. Thus, the burden of unpopular political decisions (about closing down specific facilities, for instance) would be evenly shared among the reform participants rather fall down solely onto the government.

Dr. Korotko,
Deputy Health Minister

Appendix D.
Health Policy and Reform Issues as Part of the Government Program
Summary of a public interview with Minister Serdyuk:*

A Package of Legal Documents to be adopted by the Gov't. Supreme Rada and the Cabinet of Ministers:

- Extension to Provision 49 of the Constitution
- A concept of the Health Care Sector
- "A guaranteed volume and level of health care services"
- Licensing and Accreditation of Health Care Providers
- Transfer of health care facilities, which do not play a substantial role in the government health care policy, into "community ownership under the jurisdiction of local authorities".
- Elimination of agency-based health care systems, except DOD, National Security, and Interior Ministry.
- Government, community health care providers and schools of medicine will be given the right to provide for a fee medical services beyond and above a guaranteed volume and level of services.
- Deregulation of the health care sector, except "base health care providers", such as oblast, central city and rayon hospitals, and schools of medicine.
- Reorganization of biomedical R & D institutes by means of limiting on-budget funding to the most competitive projects, while other areas of research would be transferred on full cost-recovery.
- Revision of eligibility criteria for subsidized access to drugs; introduction of targeted cash subsidy [as opposed to free access]. This approach alone would generate Krb 250 billion in drug sales revenue.
- Introduction of mandatory health insurance of a regulated amount in respect of foreign citizens, other than categories, entitled to free care by intergovernmental treaties.

Various activities are underway to reform the economics of the health care sector:

* Translated from Russian

- Reduction of on-budget funding by reconciling provider network, staffing schedules, and enrollment with the availability of on-budget financial resources.

- Human resources and bed capacity were evaluated for the period of 1991-96 at all facilities, reporting to the MOH and across all oblasts. By the end of 1996 26,829 FTE jobs and 61,493 hospital beds will be eliminated. Listed measures will allow to generate "substantial" savings. MOH believes that more effective use of funds within a determined health budget may be achieved, provided that the funding remains steady and that saved funds will be reinvested back into the health care sector.

- Taking into account tight budget, MOH submitted for approval by MOF Draft Decree of the Cabinet of Ministers on the allocation of health care resources across territories.

- Admission to free programs of medical training was reduced in 1996 by 2,000 persons, whereas the share of admission to programs with tuition paid by the students rose to 50 percent.

- Three research institutes are moved on full cost recovery, five institutes budgets are reduced by 50 percent, and another eight institutes by 20 percent. Further restructuring and downsizing are envisaged.

The Program was approved by the Cabinet of Ministers, Supreme Rada, and the President.